STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	JLTIPLE CC	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DING	01	COMPL	ETED
		155628	A. BUII B. WIN			08/29/2	011
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					CENTRAL AVE		
BRIARW	OOD HEALTH AND	REHABILITATION CENTER		l	IAPOLIS, IN46205		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX			COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	↓	TAG	DEFICIENCY)		DATE
K0000							
			1				
	A Life Safety Co	de Recertification and	K(	0000			
	State Licensure S	Survey was conducted by					
	the Indiana State	Department of Health in					
		42 CFR 483.70(a).					
	***************************************	12 011t 100.70(a).					
	Survey Date: 08	/29/11					
	Facility Number:	. 000560					
	Provider Number						
	AIM Number: 2	00139920					
	Surveyor: Mark	Caraher, Life Safety					
	Code Specialist	Caraner, Erre Sarety					
	Code Specialist						
	At this Life Safe	tv Code survev.					
		h and Rehabilitation					
		d not in compliance with					
		-					
	Requirements for	•					
		aid, 42 CFR Subpart					
		afety from Fire and the					
	2000 Edition of t						
	Protection Assoc	iation (NFPA) 101, Life					
	Safety Code (LS	C), Chapter 19, Existing					
	Health Care Occ	upancies and 410 IAC					
	16.2.	•					
	This one story fa	cility was determined to					
	_	1) construction and fully					
		-					
	-	facility has a fire alarm					
	•	ke detection in the					
		areas not separated from					
	the corridor. The	e facility has a capacity of					
					ļ		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

T5PO21

Facility ID:

009569

TITLE

If continuation sheet

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	(X2) MULTIPLE  A. BUILDING  B. WING	CONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 08/29/2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STRE 3640	ET ADDRESS, CITY, STATE, ZIP CODE  ON CENTRAL AVE  ANAPOLIS, IN46205	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	this visit.  Quality Review by I Code Specialist-Med The facility was	Robert Booher, Life Safety dical Surveyor on 09/02/11.  found not in compliance ntioned regulatory evidenced by the			
K0025 SS=E	Smoke barriers and least a one half hos accordance with 8 terminate at an atriprotected by fire-raglass panels and stwo separate compeach floor. Damper penetrations of smitheating, ventilating systems. 19.3.3.19.1.6.4  Based on observations facility failed to a through 1 of 5 smitheating failed to a through 1 of 5 smitheating failed to a through 1 of 5 smitheating failed to a smoke barrier structure materials wire to be protected to between the penesimoke barrier shamaterial capable resistance of the	e constructed to provide at our fire resistance rating in a.3. Smoke barriers may ium wall. Windows are atted glazing or by wired steel frames. A minimum of partments are provided on are are not required in duct toke barriers in fully ducted and air conditioning and air conditioning and air conditioning and air conditioning and interview, the ensure 2 of 2 openings noke barriers were attain the smoke resistance arrier. LSC Section the passage of building such as pipe, cable or atted so that the space estrating item and the all be filled with a of maintaining the smoke smoke barrier or be pproved device designed	K0025	1. The door has been repair and now shuts. The gap in the wall has been fire chalked. 2. residents in the vicinity of the smoke barrier wall between main entrance reception are and corridor to the 300 hall he the potential to be affected. 3 Maintenance Director will instead the attic monthly to ensure and breaches have occurred. 4. Results of the monthly inspections will be documen on the facility's TELS system Results of the inspections we presented to the Quality	he . All e the as nad 3. The spect no ted

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: T5PO21 Facility ID:

009569

If continuation sheet

Page 2 of 11

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTI	PLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG.	01	COMPL	ETED
		155628	B. WING	i.G		08/29/2	011
		<u> </u>		REET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	L	36	640 N	CENTRAL AVE		
		REHABILITATION CENTER			APOLIS, IN46205		
(X4) ID		TATEMENT OF DEFICIENCIES	II		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	` `	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PRE	AG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION DATE
IAG		ourpose. This deficient	17	10	Assurance Committee month	alv 5	DAIL
		fect any resident, staff or			Correction completed: 9-28-		
	1 ^				•		
		inity of the smoke barrier					
		e main entrance reception					
		idor leading to the 300					
	Hall.						
	Findings include						
	Tillungs include						
	Based on observ	ations with the Director					
	of Maintenance	during a tour of the					
		10 a.m. to 1:25 p.m. on					
	08/29/11, the fol	lowing was noted:					
		arrier wall in the attic					
	l '	or from the 300 Hall to					
		e reception area had a					
		or in the wall measuring					
	_	which was in the open					
	l -	rector of Maintenance					
	_	I secure the door but a					
		Four in the attic ceiling					
	I	from being closed.					
		ke barrier wall above the					
	l '	e 300 Hall to the main					
		on area had ten wires					
	1	igh the concrete block					
		nch gap which was not					
		nen gap winen was not					
	firestopped.  Based on intervi	over at the time of					
	· ·	Director of Maintenance					
	1	ne smoke barrier wall in					
		ne corridor from the 300					
		entrance reception area					
	had a open acces	s door in the smoke wall					ĺ

009569

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155628	B. WING		08/29/2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	3640 N	ADDRESS, CITY, STATE, ZIP CODE CENTRAL AVE IAPOLIS, IN46205	•
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
		acted from closing and			
	_	one inch gap in the wall			
	which was not fin	restopped.			
	3.1-19(b)				
K0029 SS=E	fire-rated doors) of extinguishing syste and/or 19.3.5.4 pro When the approve extinguishing syste are separated from resisting partitions self-closing and no protective plates the from the bottom of 19.3.2.1  Based on observations facility failed to a serving hazardou kitchen are provilatching device to door frame. This affect any resident vicinity of the note in the north door to equipped with a process of the serving hazardou with a proving the serving hazardou with the serving hazardou with a proving the serving hazardou with a proving the serving hazardou with the serving hazardo	em option is used, the areas in other spaces by smoke and doors. Doors are on-rated or field-applied nat do not exceed 48 inches if the door are permitted.  ation and interview, the ensure 1 of 7 doors are as such as the ded with a positive to latch the door into the stafficient practice could not, staff or visitor in the orth door to the kitchen.  ation with the Director of ing a tour of the facility to 1:25 p.m. on 08/29/11, the kitchen was not positive latching device	K0029	1. A positive latching device latch the door to the door fra was installed by the Mainten Director.2. Any resident in th vicinity of the north door to the kitchen had the potential to be affected.3. The maintenance Director will perform weekly checks and will be document on the facility's TELS system Results of the inspection will presented to the Quality Assurance Committee month Correction completed: 9-28-	me ance ee e
	to latch the door	into the door frame.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETED		
		155628	B. WING		08/29/2011
NAME OF B	DOWNER OF CHIRD IED			ET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER		3640	N CENTRAL AVE	
BRIARW	OOD HEALTH AND	REHABILITATION CENTER	INDIA	ANAPOLIS, IN46205	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	•	CY MUST BE PERCEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION DATE
IAG		LSC IDENTIFYING INFORMATION)	IAG	BETTELEXETY	DATE
	Based on intervie				
		Director of Maintenance			
	_	e north door to the			
	•	uipped with a positive			
	_	ism to latch the door into			
	the door frame.				
	3.1-19(b)				
K0050		at unexpected times under			
SS=F		, at least quarterly on each familiar with procedures and			
		are part of established			
		bility for planning and			
	conducting drills is				
		s who are qualified to			
		p. Where drills are n 9 PM and 6 AM a coded			
		ay be used instead of			
	audible alarms.	-			
		ord review and interview,	K0050	An annual fire drill schedu	le 09/28/2011
		to conduct quarterly fire		that meets regulation has be	en
		ted times under varying		set up on the facility's TELS	200.0
	•	e second shift for 3 of 4		System. The TELS System here drill/Evacuation form that	
		eficient practice affects		the time, date, shift, drill or a	I
	•	the facility including		and scenario of each fire dril	
	residents, staff ar	, .		All residents had the potentia	
	residents, stair at	14 (151016.		be affected by this practice.3  Administrator will review the	. The
	Findings include	<u>.</u>		TELS schedule, TELS system	m.
	r manigs meiude	•		Fire drill/evacuation form.4.	
	Događ oz zasi:	of "Monthly Fire and		Administrator will present the	
	based on review	of "Monthly Fire and		results of the review to the Q	uality

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: T5PO21 Facility ID:

009569

If continuation sheet

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AND PLAN OF		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	(X2) MU A. BUII B. WIN	LDING	NSTRUCTION  01	(X3) DATE S COMPL 08/29/2	ETED
	OVIDER OR SUPPLIER	REHABILITATION CENTER		3640 N	ADDRESS, CITY, STATE, ZIP CODE CENTRAL AVE APOLIS, IN46205		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES TY MUST BE PERCEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
E d No o d d O P P the No o a c c q 2	Evacuation Alarn documentation we Maintenance from 08/29/11, four drills conducted by 08/05/11 were coopen, and 3:40 p.m. he time of record Maintenance acknowledge acknowledg	ith the Director of in 9:25 a.m. to 11:10 a.m. of five second shift fire between 10/12/10 and inducted between 3:35 in. Based on interview at a review, the Director of mowledged second shift of conducted at under varying in the facility including divisitors.  of "Monthly Fire and in 1:10 a.m. in the Director of in 9:25 a.m. to 11:10 a.m. in the first quarter of interview at the first quarter of interview at the time of interview at the time of interview at the time of			Assurance Committee quarterly.5. Correction comp 9-28-11	leted:	

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628			(X2) MULTIPLE  A. BUILDING  B. WING	CONSTRUCTION  01	(X3) DATE SURVEY COMPLETED 08/29/2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	STREE 3640	ET ADDRESS, CITY, STATE, ZIP CODE IN CENTRAL AVE ANAPOLIS, IN46205	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K0076 SS=E	Maintenance ack documentation and drills being cond for the fourth quarter or 2011.  3.1-19(b)  Medical gas storagare protected in act Standards for Head Standards for Head (a) Oxygen storagare protected in act Standards for Head (b) Locations for standards for Head (c) Locations for standards for Head (c) Expansion (c) Locations for standards for Head (c) Locations for standards for standards for dealth (c) Locations for standards for standards for dealth (c) Locations for standards for dealth (c) Locations for standards for standards for dealth (c) Locations for dealth (c) Loc	nowledged there was no vailable for review of fire ucted on the third shift arter of 2010 and the first ge and administration areas coordance with NFPA 99, lth Care Facilities.  The locations of greater than closed by a one-hour supply systems of greater revented to the outside.  The systems of greater than and interview, the ensure 1 of 1 oxygen of greater than 3000 and portion of a facility is are housed, examined, paration of a fire barrier istive construction.  The aminimum distance of from combustible sparated	K0076	1. The Maintenance Director installed a 5/8 inch drywall o both sides of the existing bar that had been previously instover a previous door opening. This will provide a 1 hour rat as well as provide a 1 hour firesistive construction separathe oxygen storage and transferring room from combustive materials. 2. Any resident in the vicinity of the oxygen storage and transfilling room had the potential to be affected. 3. The maintenance Director will inspect the oxygen squarterly to provide assurance the storage rooms meeting regulatory requirements.	09/28/2011 n rrier talled g. ing, ire ting ng sen

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/20/2011 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	(X2) MULTIPLE  A. BUILDING  B. WING	01	ľ	SURVEY LETED 2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	3640	ET ADDRESS, CITY, STATE, ZIP CO ON CENTRAL AVE ANAPOLIS, IN46205	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
TAG	location is protect sprinkler system. could affect any the vicinity of the transfilling room.  Findings include  Based on observe Maintenance dur from 11:10 a.m. the oxygen storage contained five lid. The north wall of transfilling room inches tall and 30 into a former door board was not fir wall between the transfilling room which is open to the liquid oxyger stored within five board. Based on observation, the stated the woode former door from oxygen storage a acknowledged th not provide one liconstruction and combustible materials.	ted by an automatic  This deficient practice resident, staff or visitor in e oxygen storage and  the action with the Director of ing a tour of the facility to 1:25 p.m. on 08/29/11, ge and transfilling room quid oxygen canisters. If the oxygen storage and had a wooden board 78 inches wide secured or frame. The secured for frame. The secured are rated and served as a oxygen storage and and the nurse's station the corridor. In addition, and storage canisters were feet of the wooden wall interview at the time of Director of Maintenance and the nurse's station to the mod transfilling room and the wooden wall board replaced a the nurse's station to the mod transfilling room and the wooden wall board did mour fire resistive acknowledged terials were stored within	TAG	This will be document facility's TELS system of the inspection will be to the Quality Assurar Committee quarterly a compliance.5. Correct completed: 9-28-11	ted on the n.4. Results be presented nce for	DATE
	11,0 100t of the IP	quid oxygen canisters.				

Facility ID:

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE S	(3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMP			COMPL	ETED
		155628	B. WIN			08/29/2	011
			D. (12.)		DDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			3640 N	CENTRAL AVE		
		REHABILITATION CENTER		<u> </u>	APOLIS, IN46205		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
IAG		LSC IDENTIFYING INFORMATION)		IAG	BEIGHNOT		DATE
K0143 SS=E	3.1-19(b)  Transferring of oxy  (a) separated from wherein patients a treated by a separ 1-hour fire-resistiv  (b) in an area that sprinklered, and heliooring; and  (c) in an area post transferring is occur the immediate are accordance with N Compressed Gas Based on observate facility failed to transferring of ox separated from a wherein residents or treated by a set of 1 hour fire residents to transfer the staff and visitors oxygen storage at Findings include	n any portion of a facility are housed, examined, or ration of a fire barrier of e construction;  is mechanically ventilated, as ceramic or concrete  ted with signs indicating that curring, and that smoking in a is not permitted in IFPA 99 and the Association. 8.6.2.5.2 ation and interview, the ensure 2 of 2 areas where exygen takes place was my portion of a facility are housed, examined, eparation of a fire barrier istive construction. This e could affect residents, in the vicinity of the and transfilling room.	KO	TAG	1. a. The Maintenance Direct installed a 5/8 inch drywall or both sides of the existing bar that had been previously inst over a previous door opening. This will provide a 1 hour rati as well as provide a 1 hour firesistive construction separa the oxygen storage and transferring room from combustive materials. b. Who residents are on leave from t facility the liquid oxygen cani will be placed in the oxygen storage and transfilling room All residents in the vicinity had the potential to be affected.3	tor n rier alled j. ng, re ting en he sters . 2. ive . a.	DATE 09/28/2011
		during a tour of the			The Maintenance Director wi	II	
		10 a.m. to 1:25 p.m. on			inspect the oxygen rooms monthly to provide assurance	e the	
	08/29/11, the oxy	_			storage rooms are meeting	o u io	
	05/25/11, the OA	, Den storage and			regulatory requirements. This	s will	

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE : COMPL			
AND PLAN	OF CORRECTION	155628		LDING	01	08/29/2		
		103020	B. WIN		PRESIDENCE CONTROL CON	00/23/2	011	
NAME OF	PROVIDER OR SUPPLIEF	2			ADDRESS, CITY, STATE, ZIP CODE  CENTRAL AVE			
BRIARW	OOD HEALTH AND	REHABILITATION CENTER		1	APOLIS, IN46205			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE APPROPR	ΓE	COMPLETION	
TAG	<u> </u>	LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)	.1-	DATE	
	1	contained five liquid			be documented on the facility TELS system. b. Liquid oxyg	,		
		The north wall of the			canisters will only be used for	-		
	1	and transfilling room had			continous treatment orders,			
	1	78 inches tall and 36			other residents with oxygen			
	1	ared into a former door			needs will have concentrator			
	1	red board was not fire			provided. The charge nurse designee will monitor and rei			
	1	as a wall between the			all liquid oxygen canisters no			
	1	and transfilling room and			use daily during respiratory			
		n which is open to the			change over rounds.4. All re-			
	1	on interview at the time			will be presented to the Qual Assurance Committee quarte			
	of observation, the Director of				for compliance.5. Correction	Sily		
	Maintenance sta	ted the wooden wall			completed: 9-28-11			
	board replaced a	former door and						
	acknowledged th	ne wooden wall board did						
	not provide one	hour fire resistive						
	construction.							
	b. Based on obse	ervation with the Director						
	of Maintenance	during a tour of the						
	facility from 11:	10 a.m. to 1:25 p.m. on						
	08/29/11, Room	204 had one stationary						
	liquid oxygen sto	orage canister in a						
	resident room.	The stationary liquid						
	oxygen canister	was 25% full and was not						
	in use by the res	ident who was not in the						
	room. Based on	interview with the Acting						
	Administrator at	1:20 p.m. on 08/29/11,						
	the Acting Admi	nistrator stated the						
	resident had a cl	inical need to utilize the						
	stationary liquid	oxygen storage canister						
	in the resident ro	oom but acknowledged						
	the resident may	leave the facility on a						
	daily basis for of	her treatment. The						
	Director of Mair	ntenance and the Acting						
	Administrator ac	knowledged the liquid						

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155628	(X2) MULTIPLE  A. BUILDING  B. WING	O1		E SURVEY PLETED 2011
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	3640	ET ADDRESS, CITY, STATE, ZIP COL IN CENTRAL AVE ANAPOLIS, IN46205	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
TAG	oxygen canister o	bbserved in Room 204  the resident in Room	TAG	DEFICIENCY)		DATE